Gynaecology Practice
Centre for Reproductive Medicine

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Questionnaire for the man

Surname: …… First name: ……..Date of birth: …….

Address: …….....

Telephone Nr. Private: …….. Mobile: ……. Business: ……

Medical Insurance …… Occupation: ……..……..……..

Urologist …….. Email address: …….…….

Are you married to your partner? □ yes □ no Height:……Weight:…….……

1. When did your pubic and underarm hair start growing? at ……. years of age

2. When did your voice break? at ……. years of age

3. Is your beard growth? □ sparse □ average □ strong

4. Have you noticed a reduction in your energy and physical activity?

□ no □ yes since……

5. Have you noticed a decrease in your sexual performance/ability (libido) ?

□ no □ yes, since…….....

6. Do you experience problems having sexual intercourse {e.g. physical separation from partner, discomfort or pain, physical difficulties or differences of attitude with your partner) which you think could be a reason for your childlessness?

□ no □ yes ……

7. Do you have any children of your own? □ no □ yes

if yes: □ with present partner □ with other partner

8. Have you had a semen analysis (sperm test)? □ no □ yes

if yes: when where result

…… …… …….

9. Have you been treated for reduced fertility/ low sperm count? □ no □ yes

if yes: when where type of therapy / medication

…… …… …….

10. Have you had a physical examination of the genitals by a urologist, or a hormonal blood test?

□ no □ yes (please bring results with you)

11. Have you had any of the following illnesses or conditions? □ no

□ Thyroid disorder	□ Diabetes	□ Adrenal gland disease
□ Thrombosis/Embolism	□ Migraine	□ Kidney disease
□ Cardiovascular disease	□ Epileptic fits	□ Liver disease
□ Hypertension		
□ Varicose veins	□ Cancer/ Tumours	□ Mental disorders
□ Asthma/ Chronic bronchitis	□ Gastro-intestinal illness	□ Infectious deseases

□ Other: ……

12. Have you previously had problems or operations in the genital region?

□ Inflammation of testes	□ right □ left □ both sides	when…….
□ Mumps	□ right □ left □ both sides	when ……
□ Varicose veins	□ right □ left □ both sides	when ……
□ Testicular injury	□ right □ left □ both sides	when ……
□ Hernia operation	□ right □ left □ both sides	when ……
□ Undescended testicle	□ right □ left □ both sides	when …….
	□ Hormone injection treatment	when …….
	□ Operation	when …….
□ Other ……	□ right □ left □ both sides	when …….

13. Do you take medication regularly? □ no

if yes, which? ……. what for?……..
what for?…….…….

14. Are you allergic to any medication or substances? □ no
yes, to ……..……

15. Were you or are you exposed to any of the following (at work or at home)

□ Noise	□ Dust, Gas or other air pollutants
□ Solvents (Benzene Toluene Glycol ether)	□ Pesticides, Insecticides (DDT, Lindane)
□ Preservatives for leather, wood or textile	□ Disinfecting agents (Borax, Boric acid)

□ Heavy metals (Lead, mercury, Cadmium, Copper, Pewter, Silver)

16. Do you smoke? □ no □ 1-5 Cig/day □ 5-15 Cig/day □ more, approx /day

17. Do you drink alcohol? □ never □ occasionally □ regularly

18. Have any of the following conditions been diagnosed in a blood relative in your family? □ no

□ Thrombosis □ Infertility □ Cancer
□ Inherited diseases (e.g. cystic fibrosis, Muscular dystrophy)
□ Other

19. Are you inoculated against hepatitis B? □ no if yes, when last?.....

Comments: …….

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